

Insurance Coverage Information

*****Please only fill out this form if you are covered by a Blue Cross / Blue Shield PPO plan and this is the only insurance I accept. If you intend to file your own out of network claim for reimbursement, you do NOT need to fill out this form.*****

It is important you begin therapy with a clear understanding of your insurance coverage. Misunderstanding or incorrect coverage information may result in denied claims which can be very disruptive to the therapeutic process. You are responsible for all charges not covered by your insurance company regardless of reason for denial.

Have you contacted your insurance company to verify benefits? _____

Authorization Number (if needed): _____

Copay Amount: _____

Number of sessions covered: _____

Does a deductible need to be met before coverage begins: _____ If so, what is the amount of the deductible?: _____

Patient Name: _____ DOB: _____

Primary Insured (if different from above): _____

Relationship to insured: _____

Insurance Company: _____

ID #: _____ Group #: _____

Insurance companies do not pay for late cancellations or no shows. I understand I will be responsible for the full amount of the session if I do not provide 24 hours notice when canceling or rescheduling an appointment.

By utilizing health insurance, I am authorizing the release of treatment information and records as requested by my insurance company.

Patient Signature: _____ Date: _____

